(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral.* For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope.* Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope in a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, $100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(ii) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs); and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(c) *Treatment of partnerships.* [Reserved]

[T.D. 8716, 62 FR 16939, Apr. 8, 1997; 62 FR 31670, June 10, 1997. Redesignated and amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997; T.D. 8788, 63 FR 57556, Oct. 27, 1998]

§ 54.9833–1T Effective dates (temporary).

(a) *General effective dates*—(1) *Non-collectively-bargained plans.* Except as otherwise provided in this section, Chapter 100 of Subtitle K and §§ 54.9801–1T through 54.9806–1T, 54.9802–1T, and 54.9831–1T apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before

August 21, 1996, Chapter 100 of Subtitle K and §§54.9801–1T through 54.9801–6T, 54.9802–1T, and 54.9831–1T do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made pursuant to a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such Chapter, is not treated as a termination of the collective bargaining agreement.

(3)(i) *Preexisting condition exclusion periods for current employees.* Any preexisting condition exclusion period permitted under §54.9801–3T is measured from the individual's enrollment date in the plan. Such exclusion period, as limited under §54.9801–3T, may be completed prior to the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to Chapter 100 of Subtitle K of the Internal Revenue Code, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation in §54.9801–3T. For an individual who has not completed the permitted exclusion period under HIPAPA, upon the effective date for his or her plan, the individual may use creditable coverage that the individual had prior to the enrollment date to reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (a)(3):

Example 1. (i) Individual *A* has been working for Employer *X* and has been covered under Employer *X*'s plan since March 1, 1997. Under Employer *X*'s plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer *X*'s plan year begins on January 1, 1998. *A*'s enrollment date in the plan is March 1, 1997 and *A* has no creditable coverage before this date.

(ii) In this *Example 1*, Employer *X* may continue to impose the preexisting condition exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

Example 2. (i) Same facts as in *Example 1*, except that *A*'s enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example 2*, on January 1, 1998, Employer *X*'s plan may no longer exclude treatment for any preexisting condition that *A* may have; however, because Employer *X*'s plan is not subject to HIPAA until January 1, 1998, *A* is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition of *A* received before January 1, 1998.

(b) *Effective date for certification requirement*—(1) *In general.* Subject to the transitional rule in §54.9801–5T(a)(5)(iii), the certification rules of §54.9801–5T apply to events occurring on or after July 1, 1996.

(2) *Period covered by certificate.* A certificate is not required to reflect coverage before July 1, 1996.

(3) *No certificate before June 1, 1997.* Notwithstanding any other provision of §54.9801–5T, in no case is a certificate required to be provided before June 1, 1997.

(c) *Limitation on actions.* No enforcement action is to be taken, pursuant to Chapter 100 of Subtitle K of the Internal Revenue Code, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by Chapter 100 of Subtitle K of the Internal Revenue Code before January 1, 1998 if the plan or issuer has sought to comply in good faith with such requirements. Compliance with these regulations is deemed to be good faith compliance with the requirements of Chapter 100 of Subtitle K.

(d) *Transition rules for counting creditable coverage.* An individual who seeks to establish creditable coverage for periods before July 1, 1996 is entitled to establish such coverage through the presentation of documents or other means in accordance with the provisions of §54.9801–5T(c). For coverage relating to an event occurring before July 1, 1996, a group health plan and a health insurance issuer are not subject to any penalty or enforcement action with respect to the plan's or issuer's counting (or not counting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under §54.9801–5T(c).

(e) *Transition rules for certificates of creditable coverage*—(1) *Certificates only upon request.* For events occurring on or after July 1, 1996 but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies.

(2) *Certificates before June 1, 1997.* For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997, or any later date permitted under §54.9801–5T(a)(2) (ii) and (iii).

(3) *Optional notice*—(i) *In general.* This paragraph (e)(3) applies with respect to events described in §54.9801–5T(a)(2)(ii), that occur on or after October 1, 1996 but before June 1, 1997. A group health plan or health insurance issuer offering group health coverage is deemed to satisfy §54.9801–5T(a) (2) and (3) if a notice is provided in accordance with the provisions of paragraphs (e)(3) (i) through (iv) of this section.

(ii) *Time of notice.* The notice must be provided no later than June 1, 1997.

(iii) *Form and content of notice.* A notice provided pursuant to this paragraph (e)(3) must be in writing and must include information substantially similar to the information included in a model notice authorized by the Secretary. Copies of the model notice are available at the following website—http://www.irs.ustreas.gov (or call (202) 622–4695).

(iv) *Providing certificate after request.* If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in §54.9801–5T(a)(2)(iii).

(v) *Other certification rules apply.* The rules set forth in §54.9801–5T(a)(4)(i) (method of delivery) and 54.9801–5T(a)(1) (entities required to provide a certificate) apply with respect to the provision of the notice.

[T.D. 8716, 62 FR 16940, Apr. 8, 1997; 62 FR 31692, June 10, 1997. Redesignated and amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997]

PART 55—EXCISE TAX ON REAL ESTATE INVESTMENT TRUSTS AND REGULATED INVESTMENT COMPANIES

Subpart A—Excise Tax on Real Estate Investment Trusts

Sec.

Subpart B—Excise Tax on Regulated Investment Companies

Subpart C—Procedure and Administration

AUTHORITY: Secs. 6001, 6011, 6071, 6091, and 7805 of the Internal Revenue Code of 1954 (68A Stat. 731, 732, 749, 752, 917; 26 U.S.C. 6001, 6011, 6071, 6091, and 7805).

Section 55.4981–1 also issued under sec. 860(e), 92 Stat. 2849 (26 U.S.C. 860(e); sec. 860(g), 92 Stat. 2850 (26 U.S.C. 860(g)); and sec 7805. 68A Stat. 917 (26 U.S.C. 7805) of the Internal Revenue Code of 1954), 26 U.S.C. 7805.

Section 55.6011–1 also issued under 26 U.S.C. 6011(a); Section 55.6071–1 also issued under 26 U.S.C. 6071(a); Section 55.6091–1 also issued under 26 U.S.C. 6091(a).

Section 55.6151–1 also issued under 26 U.S.C. 6151.